

Thursday, March 17, 2016

Access to Care Monitoring Review Plan Overview

MEDICAL CARE ADVISORY COMMITTEE BRIEFING
KRISANN BACON



Executive Summary

Federal law requires state Medicaid programs to establish methods and procedures to ensure that Medicaid beneficiaries can access services to at least the same extent as the general population in the same geographic area (i.e., the “equal access provision”).

On November 2, 2015, the federal Centers for Medicare and Medicaid Services (CMS) published a final rule implementing the equal access provision that requires state Medicaid agencies to develop a medical assistance access monitoring review plan. The review plan must consider:

1. The extent to which beneficiary needs are fully met;
2. The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;
3. Changes in beneficiary utilization of covered services in each geographic area.
4. The characteristics of the beneficiary population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and
5. Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

Effective January 4, 2016, the new rule requires states to develop review plans and update them periodically. States must make plans available to the public for at least 30 days, finalize them, and submit them to CMS for review. The first review plan is due July 1, 2016.

The rule also creates new requirements for certain Medicaid state plan amendments (SPA). When states submit a SPA to CMS to reduce or restructure provider payments, they must submit an access review for each service affected by the SPA and monitor access to each affected service for at least three years.

The final rule excludes access reviews for Medicaid managed care arrangements. The logic behind this exclusion might be

ARMSTRONG V. EXCEPTIONAL CHILD CENTER, INC

In March 2015, the United States Supreme Court ruled that Medicaid’s equal access provision does not provide a private right of action for providers and beneficiaries to challenge Medicaid payment rates in Federal Court ([135 S. Ct. 1378 \(2015\)](#)).

In response to this and other lower court case decisions, on November 2, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a final regulation implementing Medicaid’s ‘equal access’ requirement. CMS argued that the Armstrong decision underscored the need for stronger non-judicial processes to ensure access, including (1) developing beneficiary access data and (2) reviewing the effect of changes to payment methodologies on beneficiary access.

that proposed Medicaid managed care regulations, issued on June 1, contain relevant provisions regarding both payment and network adequacy. In fact, however, CMS takes matters a step further in its rule with the sweeping statement that the equal access standard itself applies only “to state payments to providers and not to capitated payments to managed care entities.” (80 Fed. Reg. 67582.) (Rosenbaum, 2015)

State of Utah Access Review Monitoring Plan

In further efforts to provide comparable access to that which is provided to non-Medicaid enrollees, and in accordance with 42 CFR 447.203, DMHF is developing an Access Review Monitoring Plan (ARMP) for the following service categories provided under a fee-for-service (FFS) arrangement:

- Primary care services
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

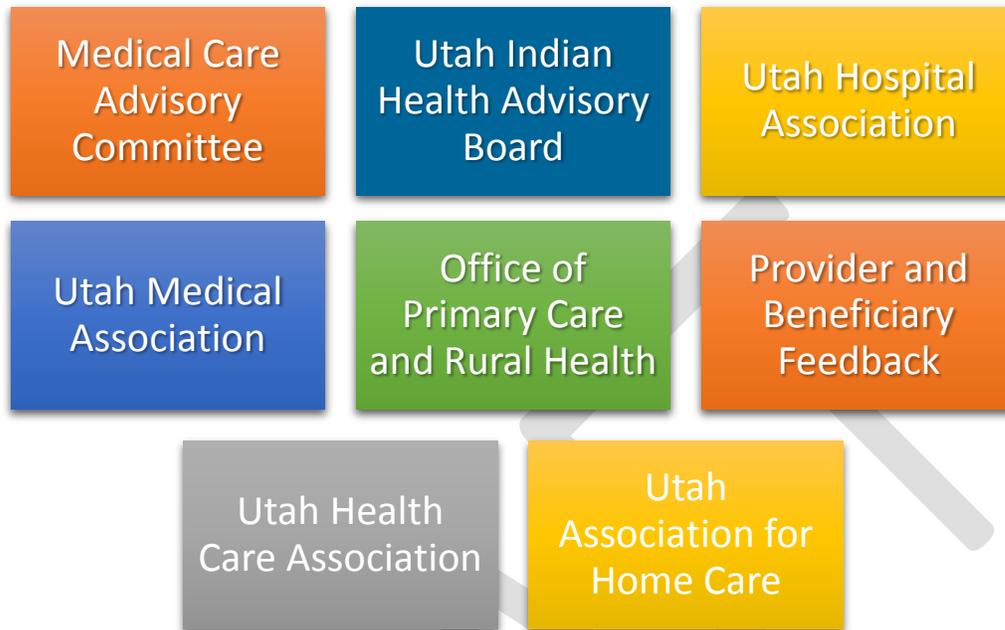
The ARMP will include a standardized, data-driven process by which DMHF documents and monitors access to care; taking into consideration the extent to which beneficiary needs are met, the availability of care and providers, utilization of Medicaid services, and a comparison of Medicaid rates and rates paid by other payers in the market.

Access to Care Monitoring Review Committee

Nate Checketts	Deputy Director, Department of Health
Krisann Bacon	Project Lead
Jennifer Meyer-Smart	Health System Reform Consultant
Blake Anderson	Consultant; Division Privacy Officer
Greg Trollan	Assistant Bureau Director, Coverage and Reimbursement Policy
Andre Baksh	Health Economist
Craig Devashrayee	Technical Writer

Stakeholder Groups

Utah's Division of Medicaid and Health Financing is currently soliciting and collecting feedback from a number of identified stakeholder groups.



Current Timeline

Task	Status	Date Due
Complete Literary Review/Gather Data	Done	1/31/2016
Consult with Economists/Statisticians	Done	1/31/2016
Construct List of Data Requirements-reimbursement amount, physician types, etc.	Done	2/29/2016
Consult with All Payer Claims Database Data Stewards	Done	2/29/2016
Begin data collection. Begin Draft Plan.	Done	3/4/2016
Brief MCAC, solicit input		3/17/2016
Brief UIHAB, solicit input		4/8/2016
Develop mechanism for Beneficiary/Provider feedback		4/10/2016
Develop monitoring procedures for rate changes		4/15/2016
Draft Plan Due		4/15/2016
Send to management for review		4/8/2016

Send to identified stakeholder groups for informal feedback	4/15/2016
Feedback/Approval from management due	4/29/2016
Informal feedback from identified stakeholder groups due	4/22/2016
Revise based on Feedback	5/2/2016
Publish for formal Public Comment	5/3/2016
Present draft plan to UIHAB	5/13/2016
Present draft plan to MCAC	5/19/2016
Public Comment Ends	6/3/2016
Revise based on Public Comment	6/10/2016
Final approval from management	6/25/2016
Submit to CMS	6/30/2016

Feedback Submission

DMHF is currently seeking informal feedback, from the MCAC, on the rule. During the developmental and formulation stage, feedback on the regulation, access to care in Utah, and/or the draft plan are requested. An informal draft of the Utah plan will be submitted to the Committee by April 15, 2016. Informal feedback is due back to DMHF by April 22, 2016.

Please submit all feedback and questions to Krisann Bacon:

Krisann Bacon

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Sources for more information:

1. For the complete Federal Regulation governing access to care: www.ecfr.gov 42 CFR 447.203 - 447.205

Exact Link: http://www.ecfr.gov/cgi-bin/text-idx?SID=8cfd8b4606a6e666f2164191c0595d26&mc=true&node=se42.4.447_1203&rgn=div8

2. For the final rule with comment period: The Federal Register, Department of Health and Human Services, CMS-2328-FC

Exact Link: <https://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27697.pdf>

3. For more general information about the Centers for Medicare & Medicaid Services <https://www.cms.gov/>

References

Rosenbaum, S. (2015, November 19). *Health Affairs*, p. 6.